Legislative Fiscal Bureau
Fiscal Note

HF 479 - Advanced Practice Nurses, Primary Care Providers (LSB 1803 HV)
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Fiscal Note Version — New

Description

The Bill provides that Advanced Registered Nurse Practitioners (ARNPs) shall be approved providers of health care services, including primary care, under the Medical Assistance Program (Medicaid) managed care contracts.

Assumptions

1. In January 2003, there were 129,265 individuals (49.2%) enrolled in the Medicaid managed care plans out of a total Medicaid population of 262,514.
2. There are two types of managed care contracts in the Medicaid Program. The first type includes contracts with private Health Maintenance Organizations (HMOs). Under the contracts, the HMOs receive an actuarially determined amount per enrolled person per month (the "capitation rate"). In the HMO program, the Department of Human Services (DHS) pays the contractor the capitation rate and the HMO is responsible for paying claims, reimbursing providers, etc.
3. A key feature of HMOs is the use of primary care "gatekeepers," (also called "primary care case managers"). The patient must enroll with a primary care provider, commonly a physician, who then authorizes referrals and services. Under DHS's contracts with the HMOs, it is at the health plans' discretion whether ARNPs can also serve as the primary care case manager.
4. The second type, called "Medipass," is used in areas of the State that do not have access to an HMO. Under the Medipass program, DHS pays a $2 surcharge to physicians to act as the patient's primary care case manager.
5. In Medipass, only a physician can be a patient's primary care case manager. Patients can access services from an ARNP, but only with a physican's referral or if the ARNP works within the physician's practice.
6. Because the HMOs are paid by a single capitation rate each month, DHS does not have data on how much was expended for physician and ARNP services. The DHS does have data on services provided in the fee-for-service system, but the data for Medipass cannot be identified separate from the rest of the fee-for-service population.
7. In FY 2002, there were 73 ARNPs enrolled as providers in the Medicaid Program. Thirty of the enrolled ARNPs submitted claims for services provided to Medicaid patients. In total (state and federal funds combined), approximately $54,000 in claims were paid for ARNP services in the managed care program. As discussed above, how much of this was due to Medipass patients cannot be determined.
8. Advanced Registered Nurse Practitioners (ARNPs) who are employed by a physician are reimbursed at the physician fee schedule because the payment is made to the provider as a whole, not to the individual employees of the provider. According to DHS, the Bill would not affect that reimbursement rate.
9. The Bill would allow ARNPs to be the primary care case manager. In general, ARNPs are reimbursed at approximately 85% of the cost of physician services. Thus, if some patients decided to use an ARNP as their primary care case manager or if more ARNPs were utilized for services rather than a physician, there would be savings.
10. In the Medipass system, the ARNP would receive the same $2 per patient per month as the physician receives to serve as a primary care case manager.

11. The HMO contract is based on actuarially determined capitation rates based on expenditures for the Program as a whole (hospital, pharmacy, etc.). In order for there to be savings in the HMO program, the savings would have to be great enough to affect the overall capitation rate. It is unknown how many patients would choose an ARNP as their primary care case manager or whether it would induce patients to switch from physicians to ARNPs for services.
12. Since ARNPs would receive the same $2 to serve as the primary manager, there would be no fiscal impact in the Medipass system.
13. This fiscal note does not include a projected savings to the health care system from increased use of ARNPs, such as reduced inpatient or prescription utilization. If increased ARNP utilization were to result in savings in other areas of the Medicaid health care system, the savings would occur in the long term.

Fiscal Impact

The fiscal impact cannot be determined.

Source

Department of Human Services

/s/ Dennis C Prouty

March 11, 2003

The fiscal note and correctional impact statement for this bill was prepared pursuant to Joint Rule 17 and pursuant to Section 2.56, Code of Iowa. Data used in developing this fiscal note and correctional impact statement are available from the Legislative Fiscal Bureau to members of the Legislature upon request.
